State: *District of Columbia* **Filing Company:** *CareFirst BlueChoice, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS*
Product Name: *DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*
Project Name/Number: *Revised Explanation of Variations/DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*

Filing at a Glance

Company:	CareFirst BlueChoice, Inc.
Product Name:	DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)
State:	District of Columbia
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.002B Any Size Group - POS
Filing Type:	Form
Date Submitted:	01/15/2020
SERFF Tr Num:	CFBC-132222249
SERFF Status:	Closed-APPROVED
State Tr Num:	
State Status:	
Co Tr Num:	DC-CFBC-LG-POS-SOB (6-16) EOV (REV 1-20)
Implementation Date Requested:	On Approval
Author(s):	Rachel Peters
Reviewer(s):	Colin Johnson (primary), RaShaunda Benson
Disposition Date:	02/05/2020
Disposition Status:	APPROVED
Implementation Date:	02/05/2020

State: *District of Columbia* **Filing Company:** *CareFirst BlueChoice, Inc.*
TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS*
Product Name: *DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*
Project Name/Number: *Revised Explanation of Variations/DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*

General Information

Project Name: Revised Explanation of Variations
Project Number: DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type:
Filing Status Changed: 02/05/2020
State Status Changed:
Created By: Rachel Peters
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:
Deemer Date:
Submitted By: Rachel Peters

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached please find a revised Explanation of Varations for Form Number DC-CFBC-LG-POS-SOB (6-16). The original form was approved by the Department of Insurance on February 16, 2016 under SERFF Filing # CFBC-130422443. The purpose of the revision to the Explanation of Variations is to allow the flexibility for Infusion Services to have No Copayment or Coinsurance for Members.

Company and Contact

Filing Contact Information

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CareFirst BlueChoice, Inc.
840 First Street NE
Washington, DC 20065
(202) 479-8000 ext. [Phone]

CoCode: 96202
Group Code:
Group Name:
FEIN Number: 52-1358219

State of Domicile: District of Columbia
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*CFBC-132222249*	***State Tracking #:***		***Company Tracking #:***	*DC-CFBC-LG-POS-SOB (6-16) EOV (REV 1-20)*

State:	*District of Columbia*	***Filing Company:***	*CareFirst BlueChoice, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS*		
Product Name:	*DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		
Project Name/Number:	*Revised Explanation of Variations/DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
APPROVED	Colin Johnson	02/05/2020	02/05/2020

SERFF Tracking #:	*CFBC-132222249*	***State Tracking #:***		***Company Tracking #:***	*DC-CFBC-LG-POS-SOB (6-16) EOV (REV 1-20)*

State:	*District of Columbia*	***Filing Company:***	*CareFirst BlueChoice, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS*		
Product Name:	*DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		
Project Name/Number:	*Revised Explanation of Variations/DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		

Disposition

Disposition Date: 02/05/2020

Implementation Date: 02/05/2020

Status: APPROVED

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanation of Variations	APPROVED	Yes

SERFF Tracking #:	*CFBC-132222249*	***State Tracking #:***		***Company Tracking #:***	*DC-CFBC-LG-POS-SOB (6-16) EOV (REV 1-20)*

State:	*District of Columbia*	***Filing Company:***	*CareFirst BlueChoice, Inc.*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS*		
Product Name:	*DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		
Project Name/Number:	*Revised Explanation of Variations/DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20)*		

Supporting Document Schedules

Satisfied - Item:	Explanation of Variations
Comments:	
Attachment(s):	DC-CFBC-LG-POS-SOB (6-16) eov (rev 1-20).pdf
Item Status:	APPROVED
Status Date:	02/05/2020

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

	Variable Shown in Form	Available Variable(s)
General	Bracketed (**[]**) text may be omitted or replaced. If a bracketed item is omitted, the remaining provisions will be re-numbered/re-lettered accordingly and appropriate adjustments made to alignment. Formatting of the tables may change slightly with all final production documents: 1) line spacing may be increased or decreased to fit information onto one page, 2) column headings which may not currently show at the top of each page will be added, 3) bolding or unbolding of print may change. The bracketed page numbers at the bottom of the page may vary according to where the document is placed in the Evidence of Coverage and according to the page number format used in the Evidence of Coverage. Ranges of variable amounts have been included. At all times, contracts generated with this form will comply with federal and state mandated Member payment/cost-sharing requirements.	

SECTION	TEXT IN FORM	VARIABLES
DEDUCTIBLE		
Deductibles	Entire section	The entire Deductible provision will be omitted when the product design does not include an applicable In-Network or Out-of-Network Deductible. In that instance the section will read [There is no In-Network or Out-of-Network Deductible.] In addition, the "Subject to Deductible column in the benefits chart will be omitted.
In-Network	[The Individual Benefit Period Deductible is $[300][1]. [The Family Benefit Period Deductible is $[600][1].][2]][3]	[1] [0-20,000] in $50 increments. For the In-Network Individual Deductible this amount shall not exceed the maximum cost-sharing amount for individual coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. For plan years beginning during the 2016 calendar year, this amount is $6,850. For the In-Network family Deductible, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. For plan years beginning during the 2016 calendar year, this amount is $13,700. The range of $20,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years. [2] *The bracketed text will be omitted when the account elects not to cover Dependents.* [3] [There is no In-Network Deductible.]
Out-of-Network	The Individual Benefit Period Deductible is $[1,000][1]. [The Family Benefit Period Deductible is $[2,000][1].][2]	[1][0-40,000] in $50 increments. [2] *The bracketed text will be omitted when the account elects not to cover Dependents.*

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

SECTION	TEXT IN FORM	VARIABLES
Text and variables to be used for both In-Network and Out-of-Network Deductibles:	[For purposes of determining the Deductible, any Type of Coverage that is not Individual is considered Family coverage.] [1] **Individual Coverage:** The Member must satisfy the Individual Deductible. **[Family Coverage**: The Deductible may be met entirely by one Member or by combining eligible expenses of two or more covered family Members. [**There is no Individual Deductible with Family Coverage.]**[2] The Family Deductible must be reached before CareFirst BlueChoice pays benefits for any Member who has Family Coverage.] [3]	[1] *The bracketed text will be omitted when the account elects not to cover Dependents.* [2] Bracketed text will be included when the form is used with a grandfathered health benefit plan or the family deductible is less than the maximum cost-sharing amount for individual coverage under PPACA. Otherwise it will be omitted. [3] [**Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, eligible expenses for all covered Members can be combined to satisfy the Family Deductible. An individual family member may not contribute more than the Individual Deductible toward meeting the Family Deductible. Once the Family Deductible has been met, this will satisfy the Deductible for all covered family members.] [7] **OR** [2] [**Family Coverage:** Each Member can satisfy his/her own Deductible by meeting the Individual Deductible. In addition, if [2] [3] [4] covered family Members separately meet their own Individual Deductibles, this will also satisfy the Deductible for all other covered family Members.] **OR** [2] [**Family Coverage:** The Deductible may be met entirely by one Member or by combining eligible expenses of two or more covered family Members.] **OR** *The bracketed text will be omitted when the account does not elect to cover Dependents* Under no circumstances will the In-Network Deductible for an individual for covered medical benefits and the separate Deductible for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

SECTION	TEXT IN FORM	VARIABLES
	The following amounts apply to the Deductible: • 100% of the Allowed Benefit for Covered Services that are subject to the Deductible. [•Amounts paid by the Member for the benefits provided under the Prescription Drug Benefits Rider.][1] [The Benefit Period Deductible will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.][2]	[1] Bracketing will allow for prescription drug benefits to be integrated or non-integrated into the medical benefits Deductible. [2] Bracketing will allow for an account to choose the applicability of the In-Network eligible expenses and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Deductibles.
	The benefit chart below states whether a Covered Service is subject to the Benefit Period Deductible. If a Benefit Period Deductible applies, the chart will also state whether the Benefit Period Deductible applies to In-Network benefits, Out-of-Network benefits or both. The following amounts may <u>not</u> be used to satisfy the Benefit Period Deductible: [• Amounts incurred for failure to comply with the Utilization Management Program requirements.][1] • Charges in excess of the Allowed Benefit. • Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. • Charges for Covered Services not subject to the Deductible. [• Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.][2] [•[Copayments] and [Coinsurance], if any, required under any riders or amendments to the Evidence of Coverage unless the rider or amendment specifically states otherwise.][3]	[1]The bracketed text will be omitted when there is no penalty for failure to comply with Utilization Management requirements [2] Bracketed text will be omitted when the Prescription Drug Benefits Rider includes the penalty described in this provision, otherwise it will be included. [3] Bracketing allows for Copayments and Coinsurance required by riders or amendments not to apply to the Deductibles.
[Deductible Carryover:	If the Member has Deductible expenses in the last three (3) months of one Benefit Period, the Member may apply the expenses toward meeting the Deductible in the following Benefit Period if the expenses apply to services that are subject to the Deductible[; and, the Member did not exceed the Deductible in the prior Benefit Period].]	*This section will be included when an account purchases a product that has a benefit design that includes a Deductible Carryover provision.* *The bracketed text within the provision will be included if the accounts elects to include the limitation.*
[Deductible Credit	If a Member was covered on the day immediately preceding the effective date of this contract under any other [compatible] group agreement issued to the group, then charges for Covered Services (as defined) incurred by that Member and applicable toward the Individual or Family Deductible under the prior agreement, shall be used to satisfy all or any portion of the Individual or Family Deductible amounts under	The term [compatible] will be removed if a compatibility requirement is not applicable. *This text will be included if an account purchases a product that includes this Deductible design.*

SECTION	TEXT IN FORM	VARIABLES
	this contract. This Deductible credit provision applies only to the Deductible amount wholly or partially satisfied in the same Benefit Period as the effective date of this contract. Deductible credit only applies to initial enrollees. Deductible credit is not available for Prescription Drugs.]	
Out-of-Pocket Maximum		
In-Network	The Individual Benefit Period Out-of-Pocket Maximum is $[2,000] [1]. [The Family Benefit Period Out-of-Pocket Maximum is $[4,000][1].][2]	[1] [0-40,000] in $50 increments. For the In-Network Individual Out-of-Pocket Maximum this amount shall not exceed the maximum cost-sharing amount for individual coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. For plan years beginning during the 2016 calendar year, this amount is $6,850. For the In-Network family Out-of-Pocket Maximum, this amount will not exceed the maximum cost-sharing amount for family coverage established under Section 1302(c)(1) of the Patient Protection and Affordable Care Act. For plan years beginning during the 2016 calendar year, this amount is $13,700. The range of $40,000 accommodates any revisions to the limits set by federal regulation for subsequent calendar years. [2] *The bracketed text will be omitted when the account elects not to cover Dependents.*
Out-of-Network	The Individual Benefit Period Out-of-Pocket Maximum is $[4,000] [1]. [The Family Benefit Period Out-of-Pocket Maximum is $[8,000][1].][2]	[1][0-40,000] in $50 increments. [2] *The bracketed text will be omitted when the account elects not to cover Dependents.*
Text and variables to be used for both In-Network and Out-of-Network Out-of-Pocket Maximums	[For purposes of determining the Out-of-Pocket Maximum, any Type of Coverage that is not Individual is considered Family coverage.] [1] **Individual Coverage:** The Member must meet the Individual Out-of-Pocket Maximum. [**Family Coverage:**. The Out-of-Pocket Maximum can be met entirely by one Member or by combining eligible expenses of two or more Members. [**There is no Individual Out-of-Pocket Maximum with Family Coverage.**][2] The Family Out-of-Pocket Maximum must be reached before CareFirst BlueChoice waives payment of the listed amounts applying to the Out-of-Pocket Maximum.] [3]	[1] *The bracketed text will be omitted when an account elects not to cover Dependents.* [2] Bracketed text will be included when the form is used with a grandfathered health benefit plan or the family Out-of-Pocket Maximum is less than the maximum cost-sharing amount for individual coverage under PPACA. Otherwise it will be omitted. [3] [**Family Coverage:** Each Member can satisfy his/her own Individual Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket Maximum. In addition, eligible expenses of all covered family members can be combined to satisfy the Family Out-of-Pocket Maximum. An individual family member cannot contribute more than the Individual Out-of-Pocket Maximum toward meeting the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum has been met, this will satisfy the Out-of-Pocket Maximum for all family members.] **OR** [2] [**Family Coverage:** Each Member can satisfy his/her own Out-of-Pocket Maximum by meeting the Individual Out-of-Pocket

SECTION	TEXT IN FORM	VARIABLES
		Maximum. To meet the Family Out-of-Pocket Maximum, at least [1] [2] [3] [4] covered family [Member OR Members] must separately meet their own Individual Out-of-Pocket Maximums. Eligible expenses of all other covered family Members can be added to these amounts to satisfy the Family Out-of-Pocket Maximum. Once the Family Out-of-Pocket Maximum is met in this manner, this will satisfy the Out-of-Pocket Maximum for all covered family Members.] **OR** [2] [**Family Coverage:** The Out-of-Pocket Maximum may be met entirely by one Member or by combining eligible expenses of two or more covered family Members.] **OR** *The bracketed text will be omitted when an account elects not to cover Dependents* Under no circumstances will the In-Network Out-of-Pocket Maximum for an individual for covered medical benefits and the separate Out-of-Pocket Maximum for covered Prescription Drug benefits, if any, exceed the Out-of-Pocket Maximum limits set by federal regulation under Section 1302(c)(1) of the Affordable Care Act or any other limit set under applicable law.
	These amounts apply to the Out-of-Pocket Maximum: • Copayments and Coinsurance for all Covered Services. [•[In-Network Deductible and][1] Out-of-Network Deductible.][2] [•Prescription Drug Benefits Rider Copayments and Coinsurance for Covered Services.][3] [•Prescription Drug Deductible.][4] [The Out-of-Pocket Maximum will be calculated based on Covered Services received by the Member on an In-Network and Out-of-Network basis combined.][5] When the Member has reached the Out-of-Pocket Maximum, no further [Copayments][6][,][and] [6][Coinsurance][6] [or][6] [Deductible][6] will be required in that Benefit Period for Covered Services. When the member has reached the Out-of-Pocket Maximum, no further Copayments, Coinsurance or Deductible will be required in that Benefit Period for Covered Services.	[1] Bracketed text will be omitted from the form when there is no In-Network Deductible. [2] Bracketed text will be omitted when the product design does not include an applicable In-Network or Out-of-Network Deductible. [3] Bracketing allows for benefits received under the Prescription Drug Benefits Rider and Prescription Drug Benefits Rider Coinsurance, if applicable, to apply to the Out-of-Pocket Maximum. [4] Bracketed text will be included when there is a separate Prescription Drug Deductible and the form is used to create a product for a non-grandfathered account. [5] The bracketed text will be included when the product design combines the In-Network and Out-of-Network eligible expenses to both the In-Network and Out-of-Network Out-of-Pocket Maximums. [6] Bracketed text will be included or omitted based on whether the product design contains Copayments, Coinsurance or both as well as a Deductible..

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

SECTION	TEXT IN FORM	VARIABLES
	The following amounts may <u>not</u> be used to satisfy the Out-of-Pocket Maximum: • Amounts incurred for failure to comply with Utilization Management Program requirements. • Charges in excess of the Allowed Benefit. • Charges for services which are not covered under the Evidence of Coverage or which exceed the maximum number of covered visits/days listed below. [• Difference between the price of a Non-Preferred Brand Name Drug and Generic Drug when a Member selects a Non-Preferred Brand Name Drug when a Generic Drug is available.][1] • [Copayments][2] [and][2] [Coinsurance][2], if any, required under any riders or amendments to the Evidence of Coverage unless the rider or amendment specifically states otherwise.	[1] Bracketed text will be omitted when the Prescription Drug Benefits Rider includes the penalty described in this provision, otherwise it will be included. [2] Bracketed text will be included or omitted based on whether the product design contains Copayments, Coinsurance or both
Utilization Management Non-Compliance	**[[Out-of-Network][1] Utilization Management Non-Compliance** Failure or refusal to comply with [Out-of-Network] utilization management requirements will result in [benefits for services associated with the Member's care or treatment will be reduced by [50][2]%.][3]**][4]**	[1] Bracketed text will be included when the utilization management requirements non-compliance penalty applies only to Out-of-Network benefits. [2] [25-75] in increments of 5%. [3] [no benefits being provided for services associated with your care or treatment] [4] [Failure to comply with Utilization Management requirements will not result in a reduction of benefits or loss benefits associated with the Member's care or treatment.]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Variables Throughout Form		
SECTION	**TEXT IN FORM**	**VARIABLES/EXPLANATION**
SUBJECT TO DEDUCTIBLE (except for Preventive Services, including Preventive Maternity Services, Contraceptive Counseling, Contraceptive Drugs and Devices, Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs, Elective Sterilization Services – for female Members Post-Partum Home Visits, Emergency Services and Urgent Care, Diabetic Equipment and Supplies, Breast Feeding Equipment and Supplies, Associated Costs for the Primary Care Medical Home Program and Total Care And Cost Improvement, Health Promotion, Wellness and Disease Management Program)	[[Out-of-Network] OR [In-Network and Out-of-Network] OR [No]	[No] [Out-of-Network] [In-Network and Out-of-Network] [In-Network and Out-of-Network benefits subject to In-Network Deductible] [In-Network Specialist and Out-of-Network] **OR** [[PCP: [In-Network and Out-of-Network] OR [Out-of-Network] Specialist: [In-Network and Out-of-Network] OR [Out-of-Network]][1] Clinic Visit: [In-Network and Out-of-Network] OR [Out-of-Network]] [1] [Professional: [No] OR [Out-of-Network] OR [In-Network and Out-of-Network]]
SUBJECT TO DEDUCTIBLE (for Preventive Services, including Preventive Maternity Services, Contraceptive Counseling, Contraceptive Drugs and Devices, Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs, Elective Sterilization Services – for female Members and Breast Feeding Equipment and Supplies)	[No]	[Out-of-Network]
SUBJECT TO DEDUCTIBLE (for Post-Partum Home Visits, Diabetic Equipment and Supplies, and Associated Costs for the Primary Care Medical Home Program)	[No]	[In-Network and Out-of-Network]* * This variable will be used when the form is used to create a high deductible health benefit plan. At all other times the Bracketed text will read [No].
SUBJECT TO DEDUCTIBLE (for Emergency Services and Urgent Care)	[No]	[In-Network and Out-of-Network benefit subject to In-Network Deductible]

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
[Prior authorization is not required for Clinic Visits/Outpatient Services rendered in a hospital, hospital clinic, or health care provider's office on a hospital campus ("Clinic Visit").]				*Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit". "Member Pays" column will be revised accordingly.*		
When multiple services are rendered on the same day by more than one provider, Member payments are required for each provider. [Members who receive outpatient services, such as office visits, rehabilitative services, diagnostic testing, laboratory tests, and radiology (except for preventive, radiation therapy, outpatient surgical, outpatient mental health and Substance Abuse, emergency and Urgent Care services), in facilities within a hospital, hospital clinic, or health care provider's office on a hospital campus may be required to pay a separate Copayment or Coinsurance per visit to the hospital in addition to the professional Copayment or Coinsurance. These providers <u>may</u> bill individually resulting in claims from both the hospital/facility and the physician or health care provider rendering care in the hospital/facility/clinic setting. It is the Member's responsibility to determine whether separate claims will be assessed.]				*Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit". "Member Pays" column will be revised accordingly.*		
Physician's Office	No variable text		[[PCP: [$[10][1] per visit] Specialist: $[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [$[10][1] per visit] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Outpatient Non-Surgical Services	No variable text		[[PCP: [$[10][1] per visit] Specialist: $[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [$[10][1] per visit]	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
			provider's office located in a hospital or hospital clinic][4]][2]	OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit		Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Laboratory Tests, X-Ray/Radiology Services, Specialty Imaging and Diagnostic Procedures						
Laboratory Tests (independent non-hospital laboratory)	No variable text		[$[10][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[60][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Laboratory Tests (outpatient department of a hospital)	No variable text		[$[10][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[70][1] per visit][2]][4]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
X-Ray/Radiology Services (independent non-hospital facility)	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[70][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
X-Ray/Radiology Services (outpatient department of a hospital)	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[70][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Specialty Imaging (independent non-hospital facility)	No variable text		[$[50][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[100][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Specialty Imaging (outpatient department of a hospital)	No variable text		[$[200][1] per visit][2]	[1] [5-750] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[250][1] per visit][2]	[1] [5-1500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Diagnostic Testing except as otherwise specified (in an independent non-hospital facility)	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[70][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Diagnostic Testing except as otherwise specified (in an outpatient department of a hospital)	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[70][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
[Sleep Studies-Member's Home	No variable text		[[$[20][1] per study][2]]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[[$[70][1] per study][2]][4]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] The service break will be omitted when there is not a separate cost share for this service. Benefits will be provided to the same extent as the appropriate service break for Non-Preventive Diagnostic Testing except as otherwise specified.
[Sleep Studies-Office or Freestanding Facility	[Prior authorization is required]	*Bracketed text will be omitted when there is no prior authorization requirement*	[[$[100][1] per study][2]]	[1] [5-300] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[200][1] per study][2]][4]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] The service break will be omitted when there is not a separate cost share for this

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
						service. Benefits will be provided to the same extent as the appropriate service break for Non-Preventive Diagnostic Testing except as otherwise specified.
[Sleep Studies-Outpatient Department of a Hospital	[Prior authorization is required]	*Bracketed text will be omitted when there is no prior authorization requirement*	[[$[200][1] per study][2]]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[300][1] per study][2]][4]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] The service break will be omitted when there is not a separate cost share for this service. Benefits will be provided to the same extent as the appropriate service break for Non-Preventive Diagnostic Testing except as otherwise specified.
Preventive Care - *The text is bracketed to accommodate changes to the federal statutory or regulatory text or any state-issued language*						
Prostate Cancer Screening	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Colorectal Cancer Screening	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
			text will always read "No Copayment or Coinsurance".	[3] [1-50] in increments of 5		Benefit] [3] [1-50] in increments of 5
Pap Smear	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Breast Cancer Screening	[At a minimum, benefits will be provided in accordance with the latest guidelines issued by the American Cancer Society.]	*Bracketed text will be omitted when there is no limitation on the benefit.*	[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
[Human Papillomavirus Screening Test	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5]
Immunizations	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Well Child Care	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Adult Preventive Care	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Women's Preventive Services (includes related services)	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
[Office Visits for Treatment of Childhood Obesity	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Professional Nutritional Counseling and Medical Nutrition Therapy	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Treatment Services						
Family Planning						
Non-Preventive Gynecological Office Visits	No variable text		[[$[20][1] per visit] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [$[10][1] per visit] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
[Contraceptive Counseling	No variable text		[No Copayment or Coinsurance]*,[1] * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	[1] [$[10][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5]
Contraceptive Drugs and Devices	No variable text		[No Copayment or Coinsurance]*,[1]	[1] [$[10][2] per visit]	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
			* Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	OR [[20]3% of the Allowed Benefit] 2 [5-500] in increments of 5 3 [1-50] in increments of 5		2 [No Copayment or Coinsurance] OR [[20]3% of the Allowed Benefit] 3 [1-50] in increments of 5
[Insertion or removal, and any Medically Necessary examination associated with the use of any contraceptive devices or drugs	No variable text		[No Copayment or Coinsurance]*,1 * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	1 [$[10]2 per visit] OR [[20]3% of the Allowed Benefit] 2 [5-500] in increments of 5 3 [1-50] in increments of 5	[$[40]1 per visit]2	1 [5-1000] in increments of 5 2 [No Copayment or Coinsurance] OR [[20]3% of the Allowed Benefit] 3 [1-50] in increments of 5]
[Elective Sterilization Services – Female Members	No variable text		[No Copayment or Coinsurance]*,1 * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the text will always read "No Copayment or Coinsurance".	1 [$[10]2 per visit] OR [[20]3% of the Allowed Benefit] 2 [5-500] in increments of 5 3 [1-50] in increments of 5	[$[40]1 per visit]2]4	1 [5-1000] in increments of 5 2 [No Copayment or Coinsurance] OR [[20]3% of the Allowed Benefit] 3 [1-50] in increments of 5 4 The service break will be omitted when the form is used to create a contract for a grandfathered group which has not opted to include the PPACA preventive benefits.
Maternity and Related Services						
[Preventive Visit	No variable text		[No Copayment or Coinsurance]*,1 * Except for a contract for a grandfathered account which has not elected the PPACA preventive benefits, the	1 [$[10]2 per visit] OR [[20]3% of the Allowed Benefit] 2 [5-500] in increments of 5	[$[40]1 per visit]2]4	1 [5-1000] in increments of 5 2 [No Copayment or Coinsurance] OR [[20]3% of the Allowed

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
			text will always read "No Copayment or Coinsurance".	[3] [1-50] in increments of 5		Benefit] [3] [1-50] in increments of 5 [4] The service break will be omitted when the form is used to create a contract for a grandfathered group which has not opted to include the PPACA preventive benefits.

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
[Non-Preventive Services; Office Visits]* * The bracketed text will read "Non-Preventive Services" when the form is used to create a contract for a non-grandfathered account or for a grandfathered account that has included the PPACA preventive benefits. The bracketed text will read "Office Visits" when the form is used to create a contract for a grandfathered account that has not included the PPACA preventive benefits.	No variable text		[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [$[10][1] per visit] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Professional Services for Delivery	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Allergy Services						
Allergy Testing and Allergy Treatment	No variable text		[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Allergy Shots	No variable text		[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Rehabilitative Services						
Rehabilitative Physical Therapy	[Limited to [30][1] visits per option (per injury or illness) per Benefit Period.][2] [Prior authorization is required for In-Network services performed in an outpatient hospital facility.][3]	[1] [60] [90] [120] [2] *No visit limitation if text is removed* [3] Bracketed text will be omitted when there is no prior authorization requirement	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Rehabilitative Occupational Therapy	[Limited to [30][1] visits per option (per injury or illness) per Benefit Period.][2] [Prior authorization	[1] [60] [90] [120] [2] *No visit limitation if text is removed* [3] Bracketed text will	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance]

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
	is required for In-Network services performed in an outpatient hospital facility.][3]	be omitted when there is no prior authorization requirement	in a hospital or hospital clinic][3]][2]	[[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	office located in a hospital or hospital clinic][4]][2]	OR [[20][5]% of the Allowed Benefit] [3] [5-500] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Rehabilitative Speech Therapy	[Limited to [30][1] visits per option (per injury or illness) per Benefit Period.][2] [Prior authorization is required for In-Network services performed in an outpatient hospital facility.][3]	[1] [60] [90] [120] [2] *No visit limitation if text is removed* [3] Bracketed text will be omitted when there is no prior authorization requirement	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Chiropractic Services	[Limited to [20][1] visits per Benefit Period][2] [Limited to Medically Necessary spinal manipulation, evaluation and treatment for the musculoskeletal conditions of the spine when provided by a licensed	[1] [30] [60] [2] *If no visit limitation text will be omitted* [3] *If the chiropractic benefit included in the product design is not limited to spinal manipulation, then the bracketed text will be omitted.*	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
	chiropractor, doctor of osteopathy (D.O.) or other eligible practitioner.][3]			separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5		[4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Habilitative Services for Children	[Prior authorization is required]		[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
[Acupuncture	No variable text		[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]][6]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5 [6] The entire service break will be omitted when the product design does not include a benefit for acupuncture.
Cardiac Rehabilitation	[Limited to [90][1] visits per Benefit Period] [2] [Prior authorization is required for In-Network services performed in an outpatient hospital facility.][3]	[1][30][60][120] [2] Bracketed text will be omitted if there is no visit limitation [3] Bracketed text will be omitted when there is no prior authorization requirement	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Pulmonary Rehabilitation	[Limited to one (1) pulmonary rehabilitation program per lifetime][1] [Prior authorization is required for In-Network services performed in an outpatient hospital facility.][2]	[1] Bracketed text will be omitted if there is no visit limitation [2] Bracketed text will be omitted when there is no prior authorization requirement	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5
Other Treatment Services						
Outpatient Therapeutic Treatment Services (excluding Cardiac Rehabilitation, pulmonary rehabilitation [, and Infusion Services]* * *Bracketed text will be omitted when the product design does not include separate service breaks for Infusion Services.*	Prior authorization is required for In-Network [chemotherapy] [and infusion therapy services]* performed in an outpatient hospital facility.	* *Bracketed text will be omitted when the product design does not include separate service breaks for Infusion Services.*	[[$[20][1] per visit][2] [and [$[50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][3]][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [3] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [4] [1-50] in increments of 5	[[$[40][1] per visit][2] [and [$[150][3] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit [5] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
[Blood and Blood Products	No variable text]					
Controlled Clinical Trial	No variable text					
[Telemedicine Services	No variable text]					
[Limited Service Immediate Care ()[Retail Health Clinics)]			[$[10][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
[Chemotherapy			[[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5	[[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [5] [1-50] in increments of 5
[Radiation Therapy			[[$[20][1] per visit][2]	[1] [5-500] in increments of 5	[[$[40][1] per visit][2]	[1] [5-1000] in increments of

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				[2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5		5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [5] [1-50] in increments of 5
[Eye Care Medical Treatment			[[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5	[[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit] [3] [5-1000] [5] [1-50] in increments of 5
[Infusion Services						
Physician's	No variable text		[$[20][1] per session][2]	[1] [5-500] in increments of 5	[$[40] per session]	[1] [5-1000] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Office				[2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5		[2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5
Free-Standing Infusion Center	No variable text		[$[20][1] per session][2]	[1] [5-500] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5	[$[40] per session]	[1] [5-1000] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5
Hospital Outpatient Department	No variable text		[$[200][1] per session][2]	[1] [5-600] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5	[$[300] per session]	[1] [5-1200] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance] [3] [1-50] in increments of 5
Member's Home	No variable text		[$[20][1] per session][2]	[1] [5-500] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance]	[$[40][1] per session][2]][4]	[1] [5-1000] in increments of 5 [2] [[20][3]% of the Allowed Benefit] OR [No Copayment or Coinsurance]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				[3] [1-50] in increments of 5		[3] [1-50] in increments of 5 [4] The Infusion Services service breaks will be omitted when the product design does not include the site of service design for Infusion Services
Outpatient Surgical Facility and Professional Services						

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Surgical Care at an Ambulatory Care Facility	No variable text		[$[50][1] per [visit][2]][3]	[1] [5-1,000] in increments of 5 [2] [day] [admission] [procedure] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit [plus a Member Copayment of $[250][1] per admission.][5]] [4] [5-50] in increments of 5 [5] *Bracketed text may be omitted*	[$[150][1] per [visit][2]][3]	[1] [5-1,000] in increments of 5 [2] [day] [admission] [procedure] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit [plus a Member Copayment of $[250][1] per admission.][5]] [4] [5-50] in increments of 5 [5] *Bracketed text may be omitted*
Professional Services Provided at an Ambulatory Care Facility	[Routine/Screening Colonoscopy is <u>not</u> subject to the [Deductible [,]] [or] [Copayment [,] [or]] [Coinsurance.]	Inclusion of the variable text will be consistent with the product option design.	[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Surgical Care at an Outpatient Hospital Facility	No variable text		[$[150][1] per [visit][2]][3]	[1] [5-1,000] in increments of 5 [2] [day] [admission] [procedure] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit [plus a Member Copayment of $[250][1] per admission.][5]]	[$[250][1] per [visit][2]][3]	[1] [5-1,000] in increments of 5 [2] [day] [admission] [procedure] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit [plus a Member Copayment of $[250][1] per admission.][5]]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				[4] [5-50] in increments of 5 [5] *Bracketed text may be omitted*		[4] [5-50] in increments of 5 [5] *Bracketed text may be omitted*
Outpatient Surgical Professional Services Provided at an Outpatient Hospital	[Routine/Screening Colonoscopy is <u>not</u> subject to the [Deductible [,]] [or] [Copayment [,] [or]] [Coinsurance.]	Inclusion of the variable text will be consistent with the product option design.	[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
INPATIENT HOSPITAL SERVICES						
Inpatient Facility (medical or surgical condition, including [maternity and]* rehabilitation) **If an account elects a benefit design that includes a more generous inpatient facility maternity benefit, then the Bracketed text will be omitted and the service break for Inpatient Facility (Maternity) will be included.*	[Hospitalization solely for Rehabilitation limited to [90][1] days per Benefit Period][2] Prior authorization is required except for emergency admissions [and all maternity admissions].[3]	[1] [30][60] [120] [2] *Bracketed text will be omitted if there is no visit limitation.* [3] *If an account elects a benefit design that includes a more generous inpatient facility maternity benefit, then the Bracketed text will be omitted and the service break for Inpatient Facility (Maternity) will be included.* [4] No variable text	[$[200][1] per [admission][2]][7]	[1] [5-1,000] in increments of 50 [2] [day] [3] [$[100][1] Copayment per day up to a maximum of $[1,500][4] per [Benefit Period][5]] OR [No Copayment or Coinsurance] OR [[20][6]% of the Allowed Benefit [plus a Member Copayment of $[100][1] per [admission][2]][6]]. [4] [50-4,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted*	[$[300][1] per [admission][2]][3]	[1] [5-2,000] in increments of 50 [2] [day] [3] [$[200][1] Copayment per day up to a maximum of $[2,500][4] per [Benefit Period][2]] OR [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit [plus a Member Copayment of $[200][1] per [admission][2]][6]]. [4] [50-8,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted*

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
[Inpatient Facility (Maternity) *Service break will be omitted when an account elects a benefit design in which all inpatient facility services have the same Member cost share*	No variable text		[$[200][1] per [admission][2]][3]	[1] [5-1,000] in increments of 50 [2] [day] [3] [$[100][1] Copayment per day up to a maximum of $[1,500][4] per [Benefit Period][2]] OR [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit [plus a Member Copayment of $[100][1] per [admission][2]][6]. [4] [50-4,000] in increments of 50 [5] [1-50] in increments of 5 in increments of 5 [6] *Bracketed text may be omitted*	[$[300][1] per [admission][2]][3]	[1] [5-2,000] in increments of 50 [2] [day] [3] [$[200][1] Copayment per day up to a maximum of $[2,500][4] per [Benefit Period][2]] OR [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit [plus a Member Copayment of $[200][1] per [admission][2]][6]. [4] [50-8,000] in increments of 50 [5] [1-50] in increments of 5 in increments of 5 [6] *Bracketed text may be omitted*
Inpatient Professional Services	[Limited to one visit per day during a covered admission]	*Bracketed text will be omitted if there is no visit limitation*	[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
[Organ and Tissue Transplants	No variable text]					

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
SKILLED NURSING FACILITY SERVICES						
Skilled Nursing Facility Services	[Limited to [60][1] days per Benefit Period] [2] Prior authorization is required.	[1] [90][100] [120] [2] *Bracketed text will be omitted if there is no visit limitation.*	[$[20][1] per [admission][2]][7]	[1] [5-1,000] in increments of 50 [2] [day] [3] [$[100][1] Copayment per day up to a maximum of $[1,500][4] per [Benefit Period][5]] OR [No Copayment or Coinsurance] OR [[20][6]% of the Allowed Benefit [plus a Member Copayment of $[100][1] per [admission][2]][6]]. [4] [50-4,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted*	[$[40][1] per [admission][2]][3]	[1] [5-2,000] in increments of 50 [2] [day] [3] [$[200][1] Copayment per day up to a maximum of $[2,500][4] per [Benefit Period][2]] OR [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit [plus a Member Copayment of $[200][1] per [admission][2]][6]]. [4] [50-8,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted*
HOME HEALTH SERVICES						
Home Health Services	[Limited to [90][1] visits per "episode of care". A new episode of care begins if the Member does not receive Home Health Care for the same or a different condition for sixty (60) consecutive days.]	[1] [40-364] Bracketed text will be omitted when there is no limitation.	[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Postpartum Home Visits			[No Copayment or Coinsurance]	[1] [$[10][2] per visit]	[No Copayment or Coinsurance]	[1] [$[10][2] per visit]

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5		OR [[20][3]% of the Allowed Benefit] [2] [5-1000] in increments of 5 [3] [1-50] in increments of 5
HOSPICE SERVICES						
Inpatient Care	[Prior authorization is required.] [Services limited to a maximum one hundred eighty (180) day hospice eligibility period] [Limited to [60][1] days per hospice eligibility period.][2]	[1] [30-365] [2] *Bracketed text will only be omitted if there is no visit limitation.*	[$[20][1] per [day][2]][3]	[1] [5-1,000] in increments of 5 [2] [admission] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5	[$[40][1] per [day][2]][3]	[1] [5-1,000] in increments of 5 [2] [admission] [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5
Outpatient Care	[Prior authorization is required.] [Services limited to a maximum one hundred eighty (180) day hospice eligibility period]	*Bracketed text may be omitted.*	[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Respite Care	[Limited to 14 days per Hospice Eligibility Period.] [Prior authorization is required.]	*Bracketed text may be omitted.* [Limited to 3 periods of 48 hours during the Hospice Eligibility Period]	[$[20][1] per day][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[40][1] per day][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
Bereavement Services	[Covered only if provided within	*Bracketed text may be omitted.*	[$[20][1] per visit][2]	[1] [5-500] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
	ninety (90) days following death of the deceased]. [Prior authorization is required.]	[Limited to the 90-day period following patient's death with a maximum of 3 visits.]		[2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5		[2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES						
Outpatient Services						
Office Visits	No variable text		[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for In-Network outpatient services, office visits subclassification. See 45 CFR 146.136.*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for Out-of-Network outpatient services, office visits subclassification. See 45 CFR 146.136.*
Outpatient Hospital Facility Services	No variable text		[No Copayment or Coinsurance][1]	[1] [$[50][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-1,000] in increments of 5	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				[3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other In-Network outpatient items and services subclassification. See 45 CFR 146.136.*		[3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other Out-of-Network outpatient items and services subclassification. See 45 CFR 146.136.*

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Outpatient Professional Services Provided at an Outpatient Hospital Facility	No variable text		[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-1000] [3] [1-50] *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other outpatient items and services subclassification. See 45 CFR 146.136.*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other Out-of-Network outpatient items and services subclassification. See 45 CFR 146.136.*
[Office Psychological and Neuropsychological Testing for Diagnostic Purposes	No variable text		[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-1000] in increments of 5 [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to*

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				requirement applied to substantially all medical/surgical benefits for outpatient services, all other outpatient items and services subclassification. See 45 CFR 146.136.		*substantially all medical/surgical benefits for outpatient services, all other Out-of-Network outpatient items and services subclassification. See 45 CFR 146.136.]*
Methadone Maintenance			[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for In-Network outpatient services, office visits subclassification. See 45 CFR 146.136.*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for Out-of-Network outpatient services, office visits subclassification. See 45 CFR 146.136.*

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Partial Hospitalization	No variable text		[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit][3] OR [[20][3]% of the Allowed Benefit] [2] [5-1000] in increments of 5 [3] [1-50] *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other outpatient items and services subclassification. See 45 CFR 146.136.*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other Out-of-Network outpatient items and services subclassification. See 45 CFR 146.136.*

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Professional Services at a Partial Hospitalization Facility	No variable text		[No Copayment or Coinsurance][1]	[1] [$[20][2] per visit] OR [[20][3]% of the Allowed Benefit] [2] [5-1,000] in increments of 5 [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other outpatient items and services subclassification. See 45 CFR 146.136.*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for outpatient services, all other Out-of-Network outpatient items and services subclassification. See 45 CFR 146.136.*
Inpatient Services						
Inpatient Facility Services	No variable text		[$[200][1] per [admission][2]][7]	[1] [5-1,000] in increments of 50 [2] [day] [3] [$[100][1] Copayment per day up to a maximum of $[1,500][4] per [Benefit Period][5]] OR [No Copayment or Coinsurance] OR [[20][6]% of the Allowed Benefit [plus a Member	[$[300][1] per [admission][2]][3]	[1] [5-2,000] in increments of 50 [2] [day] [3] [$[200][1] Copayment per day up to a maximum of $[2,500][4] per [Benefit Period][2]] OR [No Copayment or Coinsurance] OR [[20][5]% of the Allowed Benefit [plus a Member

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				Copayment of $[100][1] per [admission][2]][6]]. [4] [50-4,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted* *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all medical/surgical benefits for In-Network inpatient care. See 45 CFR 146.136.*		Copayment of $[200][1] per [admission][2]][6]]. [4] [50-8,000] in increments of 50 [5] [admission] [6] [1-50] in increments of 5 in increments of 5 [7] *Bracketed text may be omitted* *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all Out-of-Network medical/surgical benefits for inpatient care. See 45 CFR 146.136.*
Inpatient Professional Services			[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all*	[$[40][1] per visit][2]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] **OR** [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 *Pursuant to the federal Mental Health Parity and Addiction Equity Act of 2008, the benefit will always be the same as or more generous than the predominant financial requirement applied to substantially all Out-of-*

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				medical/surgical benefits for In-Network inpatient care. See 45 CFR 146.136.		*Network medical/surgical benefits for inpatient care. See 45 CFR 146.136.*
EMERGENCY SERVICES AND URGENT CARE						
Urgent Care Facility	No variable text		[$[50][1] per visit][2]	[1] [5-200] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[50] per visit]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] OR [Covered as In-Network] [3] [1-50] in increments of 5
Hospital Emergency Room (Facilities)	No variable text		[$[100][1] per visit, [waived if admitted][2]][3]	[1] [5-1,000] in increments of 5 [2] *Bracketed text may be omitted* [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] [4] [1-50] in increments of 5	[$[100] per visit, [[waived if admitted]]	[1] [5-1,000] in increments of 5 [2] *Bracketed text may be omitted* [3] [No Copayment or Coinsurance] OR [[20][4]% of the Allowed Benefit] OR [Covered as In-Network] [4] [1-50] in increments of 5
Hospital Emergency Room – Professional Services	No variable text		[$[20][1] per visit][2]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit]	[$[20] per visit]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit]

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
				[3] [1-50] in increments of 5		OR [Covered as In-Network] [3] [1-50] in increments of 5
[Follow-Up Care after Emergency Surgery	No variable text		[$[20][1] per visit][2] **[and** [[$50][1] per visit][2] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic][4]	[1] [5-200] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit".	[$[20] per visit] **[and** [[$50] per visit] if rendered in the outpatient department of a hospital/hospital clinic or provider's office located in a hospital or hospital clinic]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] OR [Covered as In-Network] [3] [1-50] in increments of 5 [4] Bracketed text will be omitted when the product design does not include a separate Member cost share for a "Clinic Visit".]
Ambulance Service	No variable text		[$[20][1] per service]	[1] [5-500] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] [3] [1-50] in increments of 5	[$[20] per service]	[1] [5-1000] in increments of 5 [2] [No Copayment or Coinsurance] OR [[20][3]% of the Allowed Benefit] OR [Covered as In-Network] [3] [1-50] in increments of 5
MEDICAL DEVICES AND SUPPLIES						
Durable Medical Equipment	[Prior authorization is required for In-Network Covered Services. In-	Bracketed text will be omitted when there is no prior authorization	[[25][1]% of the Allowed Benefit][2]	[1][1-50 in increments of 5 [2] [$[30][3] per device/supply]	[[45]% of the Allowed Benefit]	[1] [1-50 in increments of 5 [2] [$[30][3] per device/supply]

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
	Network Providers and Out-of-Network Participating Providers will obtain prior authorization on behalf of the Member.]	requirement.		OR [No Copayment or Coinsurance] [3] [5-500] in increments of 5		OR [No Copayment or Coinsurance] [3] [5-1000] in increments of 5

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Medical Devices and Supplies	No variable text		[[25][1]% of the Allowed Benefit][2]	[1][1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-500] in increments of 5	[[45]% of the Allowed Benefit]	[1] [1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-1000] in increments of 5
Diabetes Equipment	No variable text		[[25][1]% of the Allowed Benefit][2]	[1][1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-500] in increments of 5	[[45]% of the Allowed Benefit]	[1] [1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-1000] in increments of 5
Hair Prosthesis *Member cost share will be the same or more generous than the cost share for Orthotic Devices and Prosthetics*	Limited to [a maximum CareFirst BlueChoice payment of $350 for] one hair prosthesis per Benefit Period.	*Bracketed text will be omitted if there is no limitation*	[[25][1]% of the Allowed Benefit][2]	[1][1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-500] in increments of 5	[[45]% of the Allowed Benefit]	[1] [1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-1000] in increments of 5
Breastfeeding Equipment and Supplies	No variable text		[No Copayment or Coinsurance][1,*] **If the form is used to create a contract for a non-grandfathered account or a grandfathered account has elected to include the PPACA preventive benefits then this statement will always read "No Copayment or Coinsurance".*	[1] [$[30][2] per device/supply] OR [[20][3]% of the Allowed Benefit] [2] [5-500] in increments of 5 [3] [1-50] in increments of 5	[[45]% of the Allowed Benefit]	[1] [1-50 in increments of 5 [2] [$[30][3] per device/supply] OR [No Copayment or Coinsurance] [3] [5-1000] in increments of 5
[PATIENT-CENTERED MEDICAL HOME]						
Associated Costs for the Patient-	No variable text					

EXPLANATION OF VARIATIONS FOR FORM NUMBER DC/CFBC/LG/POS/SOB (6/16)

Service	Limit on Benefit (combined In-Network and Out-of-Network)		MEMBER Pays			
			In-Network		Out-of-Network	
	Text in Form	Variables	Text in Form	Variables	Text in Form	Variables
Centered Medical Home Program						

The variations for the signature, name, and title of the CareFirst BlueChoice officer will contain the information for the officer.